TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Dale J Weaver PA

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-15-3770-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I attached copies of the medical records and the product description form for review and to assist in reprocessing the claim only to get the claim denied three times."

Amount in Dispute: $1,006.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual declined to issue payment absent a hcpcs code for lidocaine in a 2% solution and because the documentation does not support that $1,006.00 is a fair and reasonable charge for the kit."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 19, 2014	J3490	$1,006.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. Texas Labor Code §413.011 provides fair and reasonable guidelines.
4. 28 Texas Administrative Code §134.1 defines fair and reasonable.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s)

- 197 – Precertification/authorization/notification absent
- 225 – The submitted documentation does not support the service being billed
- 714 – Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly corrections must be submitted 1/195 days from DOS
- 762 – Denied in accordance with 134.600 (P)(12) treatments/service in excess of DWC treatment guidelines (ODG) per disability management rules
- 891 – No additional payment after reconsideration
- 193 – Original payment decision is being maintained

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable fee guideline rule?
3. What is the criteria of Labor Code §413.011?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier denied the services in dispute with reason code 197 – "Precertification/authorization / notification absent", 772 – "Denied in accordance with 134.600(P)(12) treatments/service in excess of DWC treatment guidelines (ODG) per disability management rules" and 225 – "The submitted documentation does not support the services being billed." These denials were not supported by documentation or by the respondents' position statement and will not be considered in this review.

   The carrier also used denial code 16 – Claim/service lacks information or has submission/billing error(s)"and 714 – "Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly corrections must be submitted W/I 95 days from DOS". Review of the submitted code finds;

   - J3490 - Unclassified drugs

   28 Texas Administrative Code 134.203 (b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;" The carrier's denial is not supported as this code is found within current CPT code listing. Therefore, the service in dispute will be reviewed per applicable rules and fee guidelines.

2. The services in dispute are for Procedure code J3490, service date November 19, 2014, has a status indicator of E, which denotes codes that are excluded from the Physician Fee Schedule by regulation. CMS does not determine a price or relative value for these services. If reimbursement is justified, these services are paid at a fair and reasonable rate. This code is not assigned a relative value or payment amount. Per §134.203(f), reimbursement is provided in accordance with 28 Texas Administrative Code §134.1 regarding fair and reasonable reimbursement.

   28 Texas Administrative Code §134.1, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection 134.1(f), which states that

   > Fair and reasonable reimbursement shall:
   >
   > (1) be consistent with the criteria of Labor Code §413.011;
   >
   > (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
   >
   > (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not

provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

4. 28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that:

   - The requestor's position statement asserts that 100% of total billed charges should be paid.
   - The requestor did not support that additional reimbursement of $1,006.00 would be a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.
   - The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		September , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.